DENY REASON CODES CHEAT SHEET v. EDI

INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	**Corrective action to be taken**
(Inb837.Post.2) Reject Corrected and Replacemt	The IS will process only original (1) or voided claims (8). 05/20/2004: Replacement (7) claim are also valid. Only corrected (6) are not accepted.
(Inb837.Post.3) Verify Submitter	The submitter last or Organization Name and Submitter Identifier must be a registered provider found on the IS database. The provider must also be active on the date of service.
(Inb837.Post.4) Check for Dup claim	The same Claim Id came in 2xs. This is common for providers who submit through EDI, but should not occur for user who submit claims from Admin. This had occurred for those that submit through Admin on certain occasions where claims got suspended and were then resubmitted. Call the help desk at 213-351-1335.
(Inb837.Post.5) Verify Void Claim	The voided claim must have a matching original claim. This happens when you try to unlock the voided claim and you try to submit/resubmit. Call the help desk at 213-351-1335.
(Inb837.Post.5a) Prior ClaimID For Void/Resub	For example if the original (claim A) was denied and then resubmitted as Claim B. To void the claim, Claim B must be voided, not Claim A.
(Inb837.Post.5b) Original/Resub Status For Void	The last approved claim for a service can be voided. A single service may be submitted multiple times if it is denied multiple times.
(Inb837.Post.5c) Prev Resub Status For Resub	Attempted to Re-Submit a transaction that was not in DENIED status.
(Inb837.Post.5d) Cannot Void Previously Voided Claim	Ensure the claim has not already been voided
(Inb837.Post.5e) Cannot Void Resubmit Claim Previously Denied by Rules, CICS or DTA	Ensure that a Resub or Void cannot be sent if the parent claim was denied by the Day Treatment Authorization, IS Business Rules or CICS.
(Inb837.Post.6) Verify Receiver	The receiver of all claims must be DMH.
(Inb837.Post.7) Validate Billing, Pay To Provider, Service Location and Rendering Provider	The billing provider (2010AA_REF) must exist in the IS and be active on the service date of the claim. Use IS 290 report for verification. The Billing Provider, Service Location and Rendering Provider in the claim must be associated to each other and must be active on the service date. Ensure that if the claim is from LP Contract and is an original or resubmitted claim, the Rendering Provider must also be in MHMIS
(Inb837.Post.8) Verify Directly Operated Prov	Claims from Directly Operate providers must have DMH as the pay to provider and an organization as the billing provider.
(Inb837.Post.10) Verify Subscriber Enrollment	Verify the subscriber (client) is enrolled with DMH and is a person. Note that the value in the claim is the client's DMH ID. Also may be related to client's death date.
(Inb837.Post.11) Verify Payer	Verify the payer referenced on the inbound 837 claim is DMH.
(Inb837.Post.12) Verify Min UOFS required data	The data was missing when the claim was sent. This is an internal problem and you should be able to resubmit the claim.
(Inb837.Post.12d) Validate Rendering Provider	This is the rendering provider. The provider's internal id must be in 2310BREF_RenderingProviderSecondaryIdentification where 2310B_REF01 = "N5" Use the rendering provider (2310B_REF02) to retrieve its staff code from the repository.
(Inb837.Post.15) Verify Svc Dt - Dt of Death	If client Death Date exists in the MHMIS or the IS, the Service Date must prior to or the same.
(Inb837.Post.16) Verify Staff Time Limits	The staff time has exceeded the limit for the procedure code or minutes not to exceed 8 hours per staff person. See Procedure Codes manual at http://dmh.lacounty.info/hipaa/index.html
(Inb837.Post.17) Verify Medicare and Insurance	For contract providers, Medicare and Insurance claims are submitted before submitting through the IS. Make sure there is an amount paid even if it is $0.00. For directly operated providers Medicare amount paid should equal $0.00. For Other Insurance, both D.O.P. and C.P. may enter an amount received.
(Inb837.Post.19) Verify Late Claims for Delay R	If a claim is filed more than 6 months after the service date, there must be a delay reason code.
(Inb837.Post.21) Verify Insurance Rendering Pro	If a payer is 3rd party insurance and a rendering provider for insurance exists, it must be of type "Commercial Identifier". In addition there can only be one rendering provider of type commercial identifier
(Inb837.Post.23) Verify Birth Dt - Dt of Death	Ensure the subscriber's birth date is not after the date of death.

DENY REASON CODES CHEAT SHEET v. EDI

(Inb837.Post.25) Verify Single Service	
(Inb837.Post.27) Verify Procedure Code	
(Inb837.Post.28) Verify Svc Dt - Current Dt	Ensure the service date is not more than a year before the current date.
(Inb837.Post.29)Verify FFS 2 Rendering Prov Ta	
(Inb837.Post.30) Verify FFS 2 Plan	If the claim is from FFS 2 provider, ensure only MCF is sent as plan in the other payer loop. Note that a plan does not have to be present in the transaction.
(Inb837.Post.31) Verify FFS Medical Payer	
(Inb837.Post.33) Verify FFS Procedure & SvcTime	
(Inb837.Post.35) Verify FFS delay reason code	
(Inb837.Post.36) Verify Subscriber Info	Subscriber (client) address, City, State and Zip and demographic information should be in the claim.
(Inb837.Post.37) Verify Diagnosis Code	Ensure the ICD-9 diagnosis code converts to a DSMIV code. There may be a problem with the ICD-9 – DSMIV crosswalk. Call the help desk at 213-351-1335.
(Inb837.Post.39) Verify Medi-Cal Medicare ID	If Medi-Cal is specified as a payer the Medi-Cal ID must be in the CIN format – 8 digits and a capital letter. Cannot use all 9's and a letter. If Medicare is specified as a payer, ensure the clients Medicare ID is in the format a minimum of 9 and max of 12 (such as A12345678XYZA). MHMIS EPI2 screen format.
(Inb837.Post.42) Verify Rend Prov Medicare ID	For Directly Operated providers the system checks to see if the rendering provider has a Medicare ID in the IS system. If you believe the rendering provide is a Medicare certified provider then call the help desk at 213-351-1335.
(Inb837.Post.43) Verify LP Delay Reason Code	The delay reasin code cannot be 5,6,9,11. Please note As of June 7, 2006, delay reason code 3 is a valid code.
(Inb837.Post.45) Verify Service Time	Other and Face-to-Face time are zeroes.
(Inb837.Post.46) Verify Medicare Claims	For directly operated, make sure Medicare is specified as a payer if all conditions are met. The service location is Medicare certified. The service is Medicare reimbursable. The client has Medicare The service is not via telephone.
(Inb837.Post.46A) Validate Client Medicare Eligibility	If the client had Medi-Cal and deleted the Medicare ID on the clinical tab the user may receive error message "VALIDATE CLIENT MEDICARE ELGIBILITY" the user received message in error and should resubmit claim. Issue fixed 09/2005. If Medicare is listed on the Financial Tab, Medicare needs to be included as a payer if the Medi-Cal eligibility check also shows Medicare.
(Inb837.Post.47a) Verify SL Medicare ID	For directly operated, if Medicare claim, make sure the provider location has a Medicare ID. If Medi-Cal is the payer and can be billed, make sure the service location Medi-Cal ID is active.
(Inb837.Post.48) Client Cross Referenced	
(Inb837.Post.49) Verify Insurance Type Code	REMOVED 12/15/2004 If an Other payer in Medi-Cal or Medicare, ensure the Insurance type code is valid. • Medical = 'MC' • Medicare = 'MB' • Insurance = Anything other than MC or MB. Typically is set to 'CI'.
(Inb837.Post.50) Verify ServLocProv Mode	Validate mode of service location consist with proc code service type– Added 6/17/2004 Verify the hrp_provider.mode for the service loc (RU where the service took place). If mode = 10, then we need to make sure that for the proc code listed, hrp_DMHProcedure.Servicetype=O and hrp_DMHProcedure.DayTrmt = Y.
(Inb837.Post.51) Verify DateTime string	
(Inb837.Post.52) Verify SrvLoc MediCalID	For Local Plan Providers (DO & Contract), if Medi-Cal is a payer and can be billed, ensure the service location Medi-Cal ID is active. Medi-Cal can be billed when: • All the plans in the claim allow Medi-Cal to be billed, • And the procedure code can be converted to a Medi-Cal procedure code.
(Inb837.Post.54) Plans Need Medi-Cal as a payer or Validate Medi-Cal as a payer if plan is EPSDT/HF	The claim has MC-EPSDT or Healthy Families as a plan and the claim was not sent to Medi-cal. Check out the training film at http://dmh.lacounty.info/hipaa/co_ISMovies.htm. Select movie called Medi-Cal Eligibility and Denied Claims.
(Inb837.Post.54) Validate Medicare and Insurance Paid Amount	Ensure Medicare and/or Other Third Party Insurance paid amounts do not exceed the total claim amount.

DENY REASON CODES CHEAT SHEET v. EDI

(Inb837.Post.58) Medical billable claims service date	Service date over 12 months old and cannot be billed to MediCal.
(Inb837.Post.61) Validate Data Like bad data in address line	Resubmit Claim.
(Inb837.Post.68) Validate Void servicedate	MHMIS (and DMH Business rules) require that the discharge date = last date of servce, therefore if a discharge date exists, the last service date cannot be voided. The user must first remove the discharge date and then void. To remove discharge date, the user must make a request to EUS.
(Inb837.Post.74) Validate Billing Provider NPI for FFS Admin Claim	If claim is submitted from Admin, ensure the IS has an NPI for the billing provider. If the NPI exists, ensure it is 10 digits and passes the NPI algorithm check. NOTE: This rule assumes Medi-Cal is a billable payer – which is validated for FFS clams in a previous rule 7/1/008 (CR76-4): Ensure the NPI cannot start with zero
(Inb837.Post.75) Validate Rendering Provider NPI for FFS Admin	If claim is submitted from Admin, ensure the IS has an NPI for the rendering provider. If the NPI exists, ensure it is 10 digits and passes the NPI algorithm check. NOTE: This rule assumes Medi-Cal is a billable payer – which is validated for FFS claims in a previous rule 7/1/008 (CR76-4): Ensure the NPI cannot start with zero
(Inb837.Post.76) Validate NPI Exists in Billing Provider Node for EDI Claims	If claim is from LP Contract and Medi-Cal is a billable payer , ensure the NPI is sent in the billing provider node. If the NPI exists, ensure that it is 10 digits and passes the NPI algorithm check. For all FFS EDI claims , ensure the NPI is sent in the billing provider node. If the NPI exists, ensure that it is 10 digits and passes the NPI algorithm check. – NOTE: For all FFS EDI Claims, this rule assumes Medi-Cal is a payer - – which is validated for FFS claims in a previous rule 7/1/008 (CR76-4): Ensure the NPI cannot start with zero
(Inb837.Post.77) Rule Description: Validate LP Service Loc NPI for Satellite-School	For LP Contract claims, if the service location is satellite or public school, ensure the NPI in the EDI Claim (2010AA_NM109 where NM108 = 'XX') matches the service location NPI in the IS. Note: This check assumes Rule 76 has passed
(Inb837.Post.78) Validate Billing Provider NPI Matches IS	For LP Contract EDI Claims if Medi-Cal is a billable payer and the service location is not a satellite or public school, ensure the NPI in the EDI Claim (2010AA_NM109 where NM108 = 'XX") matches the billing provider NPI in the IS. – NOTE: This check assumes Rule 76 has passed For FFS EDI claims ensure the NPI in the 2010AA segment matches the billing provider NPI in IS. – NOTE: For all FFS EDI Claims, this rule assumes Medi-Cal is a payer - – which is validated for FFS claims in a previous rule
(Inb837.Post.79) Rule Description: Validate Rendering Provider NPI	For LP Contract EDI Claims, if Medi-Cal is a billable payer ensure the rendering provider NPI is sent in the rendering provider node. If the NPI exists, also ensure that it is 10 digits and passes the NPI algorithm check For FFS EDI claims, ensure the rendering provider NPI is sent in the rendering provider node. If the NPI exists, also ensure that it is 10 digits and passes the NPI algorithm check. – NOTE: For all FFS EDI Claims, this rule assumes Medi-Cal is a payer - – which is validated for FFS claims in a previous rule 7/1/008 (CR76-4): Ensure the NPI cannot start with zero
(Inb837.Post.80) Validate Rendering Provider NPI Matches IS	For LP Contract EDI Claims, if Medi-Cal is a billable payer, ensure that the rendering provider NPI in the 2310B segment matches the rendering provider NPI in IS. – NOTE: This check assumes Rule 79 has passed For FFS EDI Claims, ensure that the rendering provider NPI in the 2310B segment matches the rendering provider NPI in IS. – NOTE: This check assumes Rule 79 has passed. NOTE: For all FFS EDI Claims, this rule assumes Medi-Cal is a payer - – which is validated for FFS claims in a previous rule
(Inb837.Post.81) Validate Resubmit Procedure for	Ensure a resubmitted claim has a DTA MHS procedure code if the denied parent claim was also for a DTA MHS procedure code.

DTA MHS Originals	
(Inb837.Post.82) Reject Duplicate Crisis Stabilization	Do not allow duplicate Crisis Stabilization claims
(Inb837.Post.83) Validate Medi-Cal maimum Service Time	Ensure the service time is not greater than Medi-Cal Maximum Time for the procedure code.
(Inb837.Post.84) Validate Jail Payers	If the Place of Service is Jail, ensure Medi-Cal and/or Medicare are not payers in the claim.
(Inb837.Post.85) Validate Claim Plan Sequence Number	Ensure plans sequence number is valid: Plan sequence numbers must start with one and be incremented by 1 and Plan sequence numbers cannot be duplicated
INBOUND 837 INSTITUTIONAL IS BUSINESS RULES	
DenyRuleFailure	**Corrective action to be taken**
(Inb837I.Post.1) Reject Corrected/Replacemt Clm	The IS will process only original (1) or voided claims (8). If a corrected (6) or replacement (7) claim is received, the claim is rejected.
(Inb837I.Post.3) Check for Dup Transaction	Checking for duplicates in general: if a claim comes in with the same claim number, it is considered a duplicate regardless of whether it's an original, resubmit or void. NOTE: The void claim will have it's own unique claim id and the original claim id will be referenced
(Inb837I.Post.4) Validate Void Claim	If the claim is a void or resubmitted claim (2300_CLM05 = "8" 0r "7") ensure its associated original inbound claim exists.
(Inb837I.Post.4b) Original/Resub Status For Void	If there is only an original claim it cannot be denied. If there is an original and one or more resubmitted claims, the last resubmitted claim cannot be denied and all the others must have been denied. In addition, if the last resubmitted claim is a Void, it must be denied due to rules.
(Inb837I.Post.6) Verify Bill & Pay To Prov	
(Inb837I.Post.7) Verify Attending Provider	Ensure that the rendering provider associated with the inpatient claim is current and not expired.
(Inb837I.Post.10) Verify Min MHMIS Reqd Data	
(Inb837i.Post.13) Validate Medicare and Insurance Coverage	Ensure Medicare and/or Other Third Party Insurance paid amounts do not exceed the total claim amount.
(Inb837I.Post.15) Verify Late Claims	If a claim is filed more than 6 months after the service end date, there must be a delay reason code.
(Inb837I.Post.20) Verify Procedure Code	It appears that the user may be modifying the procedure code, by deleting the modifiers which is causing the problem, or modifying the procedure code when submitting the claim on the Administrative side.
(Inb837I.Post.21) Verify Svc Dt <= Curr Date	Ensure the service date is not more than a year before the current date. REMOVED 12/15/2004
(Inb837I.Post.22) Verify Subscriber Info	Ensure the subscriber's Address, Zip and demographic exist in the transaction.
(Inb837I.Post.23) Verify Srv Dt Range	This is caused by an inpatient episode running across 2 months and then a service is submitted where the service date range crosses from one billing month to the next. Services must remain within a month. (So split the service into two, submit one claim for one month and then another for the next.)
(Inb837I.Post.28) Client Cross Referenced	Verify the Client ID has not been cross referenced with another Client ID.
(Inb837i.Post.38) Validate Client Medicare Eligibility	If the client had Medi-Cal and deleted the Medicare ID on the clinical tab the user may receive error message "VALIDATE CLIENT MEDICARE ELGIBILITY" the user received message in error and should resubmit claim. Issue fixed 09/2005. If Medicare is listed on the Financial Tab, Medicare needs to be included as a payer if the Medi-Cal eligibility check also shows Medicare.
(Inb837.Post.5.2.E1) Validate Client Plans	For all claims (LP and FFS), ensure the client is actively enrolled and approved for all the plans specified in the claim. To enroll a client in a plan (adda plan) you must do an update enrollment. For instructions on how to do an update enrollment go to http://dmh.lacounty.info/hipaa/do_UsingtheIS.htm
(Ensure LP Service Location has Rate Table(Inb837.Post.5.2.E2)	If the claim is from Local Plan provider, ensure the service location has rate table.

DENY REASON CODES CHEAT SHEET v. EDI

(Inb837.Post.5.2.E3) Ensure LP Service Location has Rate for Claim Plans and Procedure Code	If the CPT code in the claim is not billable under the Plan (i.e. Crisis Intervention is not allowed under AB3632) the claim will be denied, even if there is another Plan in the claim with the same CPT code that is billable to Medi-Cal (Crisis Intervention is billable under EPSDT). Call help desk for report at 213-351-1335.
(Inb837.Post.5.2.E4) Ensure LP Rendering Provider has a Taxonomy	If the claim is from Local Plan provider, ensure the rendering provider's taxonomy can perform the service. If you receive this error, resubmit -- This edit has been suspended.
(Inb837i.Post.5.2.E1) Validate Client Plans	For all claims (LP and FFS), ensure the client is actively enrolled and approved for all the plans specified in the claim.
(Inb837i.Post.5.2.E1) Ensure LP service location (RU) has a rate table	If the claim is from Local Plan provider, ensure the service location has rate table.
(Inb837i.Post.5.2.E3) Ensure LP Service Location has Rate for Claim Plans and Procedure Code	If the claim is from Local Plan provider, ensure the service location's rate table contains the claim plans and procedure code. If the claim does not contain any plans check rate table for CGF. Either "trash can" the plan when submitting the claim or do an Update Enrollment. Instructions for doing an Update Enrollment are at http://dmh.lacounty.info/hipaa/do_UsingtheIS.htm
(Inb837i.Post.5.2.E4) Ensure LP Rendering Provider has a Taxonomy	If the claim is from Local Plan provider, ensure the rendering provider's taxonomy can perform the service. If you receive this error, resubmit – This edit has been suspended.
(Inb837I.Post.4b) Original/Resub Status For Void	If there is only an original claim it cannot be denied. If there is an original and one or more resubmitted claims, the last resubmitted claim cannot be denied and all the others must have been denied. In addition, if the last resubmitted claim is a Void, it must be denied due to rules.
(Inb837I.Post.20) Verify Procedure Code	It appears that the user may be modifying the procedure code, by deleting the modifiers which is causing the problem, or modifying the procedure code when submitting the claim on the Administrative side.
(Inb837I.Post.21) Verify Svc Dt <= Curr Date	Ensure the service date is not more than a year before the current date. REMOVED 12/15/2004
(Inb837I.Post.22) Verify Subscriber Info	Ensure the subscriber's Address, Zip and demographic exist in the transaction.
(Inb837I.Post.23) Verify Srv Dt Range	This is caused by an inpatient episode running across 2 months and then a service is submitted where the service date range crosses from one billing month to the next. Services must remain within a month. (So split the service into two, submit one claim for one month and then another for the next.)

DENY REASON CODES CHEAT SHEET v. EDI

Day Treatment (DT) Error Messages			
DT Error Code	**Message/Description**	**Archived MHMIS Error Code**	**Message/Description**
ISDT02	Web Service is not available. Please Call the Help Desk at (213) 351-1335.	New Error Code	N/A
WSC01.1	Pre Validation Failed. Invalid Date Format.	New Error Code	N/A
WSC01.2	Pre Validation Failed. Invalid UofS.	New Error Code	N/A
WSC01.3	Pre Validation Failed. Invalid Procedure Code.	New Error Code	N/A
WSC01.4	Pre Validation Failed. Invalid Reporting Unit.	New Error Code	N/A
WSC01.5	Pre Validation Failed. Invalid Service Type.	New Error Code	N/A
WSC02	Day Treatment database is not available. Please call the Help Desk at (213) 351-1335.	LAMHDT10	LAMHDT10-DB2 ERROR; UPDATE HMTPAUTH -999
WSC04	DTI/DR Duplicate Claim	LAMH6019	LAMH6019 - DUPLICATE DAY TREATMENT
WSC05	Resub claims are not allowed for DTI/DR claims. Void and submit an original.	New Error Code	N/A
WSC06	WSDTArchive Failed. Please call the Help Desk at (213) 351-1335.	New Error Code	N/A
WSDT01	No DTI/DR Authorization Found	LAMHDT02	LAMHDT02-NO DR AUTHORIZATION FOUND
		LAMHDT03	LAMHDT03-NO DTI AUTHORIZATION FOUND
WSDT02	No DTI/DR days left for original claim. No DTI/DR days used for void claim.	LAMHDT08	LAMHDT08-NO MORE DAY LEFT FOR DR AUTH
		LAMHDT09	LAMHDT09-NO MORE DAY LEFT FOR DTI AUTH
WSDT03	DTI/DR HMTPAUTH update failed. Please call the Help Desk at (213) 351-1335.	LAMHDT10	LAMHDT10-DB2 ERROR; UPDATE HMTPAUTH -999

DENY REASON CODES CHEAT SHEET v. EDI

Day Treatment (DT) Error Messages			
WSMHS01	No MHS Authorization Found	LAMHDT04	LAMHDT04-NO MHS AUTHORIZATION FOUND
WSMHS02	Original claim not enough MHS hours left. Void claim no hours used for the week.	LAMHDT06	LAMHDT06-NO MORE HOUR LEFT FOR MHS AUTH
WSMHS03	MHS HMTPAUTH update failed. Please call the Help Desk at (213) 351-1335.	LAMHDT10	LAMHDT10-DB2 ERROR; UPDATE HMTPAUTH -999
WSMHS04	MHS re-sub hours must be less than or equal to remaining hours.	LAMHDT06	LAMHDT06-NO MORE HOUR LEFT FOR MHS AUTH
WSMHS05	MHS re-sub validation error. Void and submit an original claim.	LAMHDT10	LAMHDT10-DB2 ERROR; UPDATE HMTPAUTH -999
WSMHS09	MHS Re-sub error. Please call the Help Desk at (213) 351-1335.	New Error Code	N/A